NATIONAL INSTITUTE
FOR WORKERS IN SOCIAL SERVICES
IN AGENCIES SERVING BLIND PERSONS

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I - INTRODUCTION

As part of its program of continuing education in the professions applicable to the field of blindness, the Foundation conducted a National Institute for Social Workers in 1969. The response to invitations for that institute were so enthusiastic that not all could be accommodated. It was decided to limit that institute to graduate social workers, as it was assumed that their work assignments would be much more similar. It was recognized that there was a great need for a similar institute for social service workers with less than full professional training, and plans were begun for such an institute for 1970.

The National Institute for Workers in Social Services, the proceedings of which follow, was held in April, 1970 in Chicago. Again this year there was a tremendously enthusiastic response to invitations and the original number of participants planned for it had to be expanded. This institute was truly national in scope: thirty-eight participants came from twenty states, representing the length and breadth of the country, from Oregon to Massachusetts, to Louisiana and Texas. Many of these staff members had only recently entered agencies serving blind people, many were recent college graduates, while some had considerable experience.

It was anticipated that there would be greater diversity in the kinds of duties and responsibilities of these participants than those of the previous year since they had less than full graduate training. Therefore, to assist those engaged in planning the institute to make it most relevant to the participants in their diverse assignments, a questionnaire was sent to them in advance requesting them to list their primary duties, their suggestions as to areas in which the institute could be helpful to them, and to indicate their willingness to submit case material. (A copy of the questionnaire is in the appendix.)

Thirty-one of the participants responded to the questionnaire with a careful listing of their primary duties as they saw them, and thoughtful and sincere answers as to areas in which they considered they had problems and wanted help. As was anticipated, there was great diversity in their job descriptions. In their requests for help and their description of problem areas, however presented, any experienced educator of social workers could recognize the common, basic problems with which students and beginning practitioners struggle: whether to give one's attention to the problem and its solution, or to concentrate on understanding the person who has the problem; how does one learn to juggle these two aspects and give both appropriate attention as needed; how does one motivate the client to use existing services and resources; how can one deal with the resistant client? Though not fully articulated, the responses indicated struggles with their own feelings about blindness, with the emotions and personalities of their clients as they became exposed to them in the learning process. The responses clearly indicated a desire to learn, a desire to increase their competence, and a desire to provide better service.

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II - GENERAL SESSIONS

A. Setting the Stage--Where Are We and Where Are We Going?

Dr. Alan Klein, Professor
School of Social Welfare
Albany, New York

To begin, I would like to say that I hope to capitalize on the expertise represented here and would like to interact with all of you in a verbal dialogue. I would like to displace myself as an authority and rather serve as a means for obtaining an objective exchange of ideas during which we shall focus on the helping process and the underlying emotional components. This is an opportunity to decide and to exchange and to use what is most useful.

I would like to emphasize my own limited knowledge of work with blind persons. My purpose is rather to enunciate what is involved in working with people. In talking with you, I will try to be theoretical and consider some of the basic concepts and general principles with which we must be concerned when working with people. Later in the program, the second speaker will direct herself to problems raised within your experience and her own in working with the blind person.

This will be a dialogue and the general format in which I hope you will feel free to raise questions and to object. In this I would like for all of you to consider that we are partners in an enterprise about how to work better with blindness.

When we start as caseworkers, it seems we start with the concept of working with blind persons; rather the problem is how to work with people. People are people; blind people are more similar to those not blind than to those that are, and respond in different ways to stress. Blindness is a stress. We could say that it is an unusual stress, but an individual still responds in different ways and various factors predominate his response.

The goal is to identify the problem with which we can work, to consider methods of coping with whatever is troubling the person and resources and use them and then learn different methods of adapting. It may be possible for a person to alter some aspects of the way he thinks about himself and this will alter his way of coping. However, it is not enough to cope and adapt. We must have some sense of control of the environment, and circumstances act to interfere. Without some feeling of mastery there is a feeling of powerlessness, of diminishing self-worth and adequacy. People cannot be happy or feel adequate only by receiving. They need to feel able to give, also. To have a sense of real self, one must not simply be involved in adaptation.

Let me say that all behavior is purposeful. Everyone must find his real self. He must know where he fits in the whole situation. He must know how to find out, how to grow up, how to discover what one is,

rather than what is imposed by others--mother, teacher, social worker. The client must do it his way in order to realize what he is and how to be it. The ability of the worker to divest himself of his own way of doing and thinking is imperative. He must try to get inside the client's self. We must see the client and his situation through his sensitivities, to perceive his problems as he sees them in his frame of reference and within his impinging environment. He has a self-image and a self-concept and he needs the feeling of self-adequacy. Feelings of dependency and powerlessness conflict with these needs.

To be is to have some sense of power to create, do, make. If you can do something, you are someone. The only other way is to be nothing. If we take away the ability to do, this is to take away the concept of feeling. Talking about ability to achieve, it is the test of a caseworker's ability to help the client actually do this; that is, actually to achieve, to assist his yearning for mastery. The client must be stimulated to participate in the study of his problems, use his own resources, along with whatever resources are available and appropriate in the community.

One must be careful about what type of learning is being reinforced. We must examine quite often what we're reinforcing and help develop the ability to do in a positive way. In the case example which we will examine, you see that the doctor deprives and denies the affirmation of the patient's being alive.

People must be able to feel free of dictatorial control, to feel free of being put down, free of institutionalization, free of the inevitabilities of fate, free of dependency, free to express how one feels. If there is no autonomy for the client, there is no treatment but a classical putdown. If there is no mutuality, there is no sensitivity. The worker must realize the mutuality. If the worker cannot accept the client as an equal, he may give the client a sense of social insecurity. He is not helping the client feel secure with self. This is not to be confused with reality dependency. If one cannot do something, help is appropriated. This is conveyed by attitudes. We are equals and each of us needs some help. We must help the client find his way, and not force our answers upon him. If the client cannot derive a sense of security within the relationship with the worker, the client feels no human respect for himself. Respect derives from a relationship with another person who shows him respect. In each situation a person needs communication. He needs to be able to express and discharge his energy in communication with other people with emotional content. All people need contact with others. There must be an input and output between self and others.

One must divest one's self as a caseworker. In casework, there is not only verbal language, there is body language which is very important. A worker must be two people--one cannot be only the social worker; one must be at the same time also a human being. The basic ingredients of casework are not words, but a relationship. Casework is not a worker or client controlling the other, but it is two people involved. The question is whether the caseworker can really accept feelings. What is

normal for people whose basic feelings are not acceptable? We must help people to learn that we can express feelings and that they can be verbalized. Clients learn from such experiences how to handle their own feelings which may not be acceptable.

The role of the caseworker, then, is to administer practical services and offer counseling in such a way as to arouse and conserve the psychological energies of the client. Casework, simply defined, is help with personal aspects of ordinary living. It involves:

Practical services
Manipulation of environment
Direct counseling
Modification of attitudes and behavior

It involves support, awareness, learning. It must occur and be based on a relationship. The intent is to provide a proper climate for conditioning and cognitive restructuring consisting of:

Support of client's resources
Emotional catharsis and not punishment
Suggestion for better adaptation and problem solving
A live relationship.

When we fail, we must examine why we fail. We must question whether there was a lack of empathy.
We must question whether there was an excess of empathy.
We must examine whether there was a lack of sensitivity.
Was there a lack of intuitive understanding?
Was there a countertransference? In other words, have our own feelings interfered with our understanding perception of the client's needs?
Was there a lack of insight into our own problems and needs?
Is there emotional instability?
Was there a lack of flexibility in understanding and planning and carrying out plans?
Was there a lack of conviction in our own system?
Was there a lack of confidence in our own ability to be of help?
Are there restrictive traits within the client or within our own practice?

Success in the casework relationship does not depend entirely on skills and techniques and certainly is not found in a "bag of tricks." It is the ability to promote a meaningful emotional communication.

B. Challenging Traditions

Mrs. Lucy Chappell, Director
Lawndale Mental Health Center
Chicago, Illinois

In response to a questionnaire which was sent out to participants by AFB as an aid inthe planning of this institute, I had an opportunity to review the first sixteen letters received from staff who are working in agencies serving blind persons. This was a small proportion of those attending the institute and only a portion of the total responses to the questionnaire. You had been asked to describe your duties and to suggest areas that would be helpful for you to learn about at this institute. The following discussion is based on my analysis of what were hoped to be representative responses to these questions, and the evident needs for help which were expressed. The following is a partial summarization of the expressed topics for discussion in relation to the job a worker was doing.

The most commonly reported duty was to counsel, advise or otherwise directly communicate with blind persons. A review of the descriptions of the counseling raises a serious question as to the nature of counseling that is being done with blind persons. A recurring theme seemed to be that there is a reaction pattern and attitude that the blind person is supposed to maintain, and the respondents supervised the process of the blind subject's attaining the desired attitude. A common description of counseling was couched in terms of very broad, highly desirable objectives such as realizing objectives or personal and social readiness which would not seem to rule out anything that one might want to give as an objective to a blind person. One worker seemed to have the duty of telling the blind person those hard facts of life that the ophthalmologist was somehow unable to convey to his patient.

The second most frequently mentioned activity required the worker to handle referrals and communications with other agencies. One writer sought to widen the range of referral sources for helping blind persons in his community; another sought to glorify his agency in the community; one respondent tried to locate agencies to help maintain blind trainees upon their return to the community. Most respondents did not specify why they contacted other agencies.

Others reported counseling the families of the blind person. There seemed to be a theme of conveying the proper attitudes for families in relation to their blind member. It is understood that besides not having sight, blind persons are also human beings who may be loved, hated or rejected by their families and who may, in turn, antagonize, abandon, vilify or manipulate their families in as many ways as their imagination permits. No one seeking to influence or counsel people can hope to be effective until he learns that the family does not need to be present to undermine or bolster the social worker's efforts; nor can the worker assume that he need only to concern himself with understanding the client but must extend his interest also to gain knowledge of the client's environment.

Another activity assigned to the worker was conducting recreation and pastime activity programs for blind persons. One writer reported her recreation groups included visually impaired as well as sighted people, making it unclear if that group contained any totally blind persons.

Also mentioned as problem areas were intake, case study, recording, and scheduling of appointments for clients. One reporter scheduled medical appointments for blind clients and drove them to and from the doctor's office. She did not indicate if any of them had any family or friends, or any inclination to find theor own way to the doctor.

A wide variety of other activities was mentioned and concern expressed: content about confidentiality, interpreting eye reports, volunteer coordination, developing knowledge and awareness, promoting harmony among staff, teaching, arranging funds for surgery, home visiting, financial assistance.

Most of the respondents felt they would like to learn the dynamics of the interaction between the helper and his unresponsive client. Typical questions seemed to look for a magic formula which, properly applied, would yield the desired outcome. Although some of the questions reflect a lack of awareness of human psycho-social interaction, the situation is by no means hopeless. Most workers are aware of their difficulties and, however stated, request information that it seems should have been given to them in orientation to the agency and before they were confronted with the complexities of counseling.

Also recurring in the responses was a request for discussion of the mental disturbance supposed to accompany blindness. The correspondence is not definitive, but I have the uncomfortable feeling that there may be people working with blind persons who believe that blindness causes illness, or that blindness and mental illness go together, which idea is totally inaccurate.

Other requests for discussion mentioned more than once were medical information, case record keeping and organization, recreation for blind people, client transportation, and educator's low expectations for blind students, the need for vocational training, the lack of vocational opportunities, conducting public relations. There seems to be a need for ophthalmologists to be frank with newly blinded patients. There is need for increased skill in use of family therapy. There are questions regarding the "security blanket" of programs of assistance for blind persons versus the guaranteed annual wage and working with the partially sighted in the public schools. Only these last two seem likely to place the handicapped person in the real world, and the only worker who mentions the guaranteed annual wage reflects a desire for blind persons to join the rest of humanity.

There are many different definitions of social work. However, there is one theme basic to all definitions, and that is the sensitivity

to the needs of the individuals, the helpfulness and the restoration of individuals to peace of mind and well-being. This does not sound so complicated that we would have to separate those endowed with a master's degree to help people from those not so endowed. Most of you are non-master's persons with varying backgrounds and experiences. You no doubt have different titles such as sub-professional, para-professional, non-professional, semi-professional, Human Services Counselors, Community Aides, Neighborhood Workers, Mental Health Aides, Casework Aides, and New Careerists. Whatever title you have been saddled with should not dictate your directional path of helping people. You have come here with certain attitudes and feelings about your job. You have brought everything that Eric Berne talks about in his transactional analysis; that is, in every person there is a parent, child and adult.

You are no doubt working in a setting where the fully trained professionals have the same endowments. You have set yourselves apart from your fellow workers in some instances because of the need to survive. In other instances, possibly because of whatever it is about you as a person, you feel subordinate to the "professionals"--but my question is whether you wouldn't still have those feelings whether you are a <u>professional</u> or <u>non-professional</u>. Does it matter?

What is common is that many of us cannot adjust to our own feelings about some of the people we are trying to help. In the helping relationship we may need to help people who may not think as we do; they may deny that they need help, may resist it, may be angry, suspicious or not tell the truth about themselves. How do we deal with this behavior, their feelings and reactions? Some problems will take forever to solve. Can you find ways to speed things up and to be helpful? Some problems may need the cooperation of several agencies. Which ones? How do you help people to help themselves without taking over yourself? There are no simple single final answers to any of these questions, but there are some observations I can make which may help you.

If you are a beginning worker, this paper aims to help you with your job ahead. If you are a more experienced worker, this paper will attempt to stimulate some new ideas about your work. There is always the haunting question, "How can we do it better next time?"

It seems to me that the tradition being challenged is that the old accepted traditional organizations and methods of delivery of services most effectively meet the need of their client populations. There is some evidence that they fail badly, that existing systems tend to become huge, complex, bureaucratic structures which drain funds, impede delivery of services to clients, and fail to make use of manpower resources.

There are not enough trained social workers, and some of the reasons are obvious: (1) Professional preciousness demands that limitations be devised to insure that there be fewer annointed with so-called skills; (2) The certificates and degrees MA-ACSW, Ph.D., M.D. "prove" possession of a rare skill in the professional; (3) Status considerations can be

used to minimize interaction with beings of lesser status; (4) As administrators in developing innovative programs, we often find it difficult to resist hiring the professionally prepared person who represents academic title and security, rapid professional recognition, political power and station or role in local community activity. There are two options that we can consider: accept them, we won't be hurt; or don't accept them, and experiment with new modes of delivery. I take the latter; therefore, the only issue with me has been how do we do this? We must have guts to risk failure, but too many of us don't have guts.

Despite the resistance from the professionals to hiring less than fully trained personnel, the non-professional can be an important source of pressure for change on both the service system and the professional. The exact direction of this change is not determined by the contribution of the non-professional, although his non-specific effect is discernible. His general impact is in the raising of questions concerning the relevance of traditional practice and the organization of the service system --its rules, customs, traditions, pseudo-professionalism and ritual. If properly directed, this could lead to a much more authentic professional practice which is the goal of the New Careers program. For this to take place, however, a close and intensive interchange between the professional and non-professional is required.

For many years professors have been instructing students in universities how to become social workers; some of what has been taught has not been useful in our everyday experiences. There is a need for practical help to agencies training and using those persons who are not fully professionals, and here he must consider the variance of training. Some have one degree, others high school, others some college training, others no degree in the human service field. I don't have correct answers, any one practice, attitude, course of action, or point of view because no one person can decide on the right one outside a given context, need and goal.

The first who must be accepting of the idea of using the non-graduate person are the administrators and professionals. They need to be clear about their motivations and feelings. In selecting staff one of the criteria might be what Supreme Court Justice Oliver Wendell Holmes called "White Magic." When a would-be politician asked Justice Holmes for advice on how to get elected to office, Justice Holmes wrote him: "To be able to listen to others in a sympathetic and understanding manner is perhaps the most effective mechanism in the world for getting along with people and tying up their friendship for good." Too few people practice the "White Magic" of being good listeners.

I do know that training is necessary to get some jobs done. The non-professional without training may be a menace to the service. Not only is he unaware of his active role, he also has no idea of what he must not do. Shulman states that in the final analysis, the evaluation of the efficacy of any theory must rest upon its impact on the provision of service. In social work education, it is the field work experience

that provides the opportunity for students to put theory to this test. The demand for service from the client and the realities of working in a social agency force the student to make connections between broad theoretical formulations and his specific practice problems. When this vital connection is made, students begin to own a theory as a valuable part of their professional equipment.

I agree with this, but why cannot the same thing apply to workers in agencies who do not have master's degrees or even bachelor's degrees? It has never made much sense to me to use an agency as a field placement for graduate students while workers in that very agency need training. As a director of the Lawndale Community Mental Health Center, I entered a reciprocal agreement with a university: "If I teach your students, you teach my workers." The result: a relevant staff development training program called "Professional Development for New Careerists" for all workers in the Center, prospective employees, clerical as well as workers, who wished to participate from the other center.

Some studies point to the inadequacy of programs and the ineffectiveness of the most frequently employed teaching techniques. In my opinion, learning has been largely incidental and primarily left to the interest and initiative of the individual. Training must be job related rather than general. Upon questioning, many people respond that they are not being taught what they need to know. Then, what do they need to know? How can we find out? Ask them. This is where I began.

Two planning conferences were held with the workers and University professors. The workers made a course outline with the understanding that if revisions as seen by the workers, not administrators or teachers, were necessary as the classes progressed, there was this flexibility. The interesting observation was that there were many similarities that these employees pointed out as course content to that discussed in other agencies by non-degree workers.

The above is not enough; there has to be a continuous growth process. Trainees must be taught to relate positively both to other members of the staff and to persons in their care. I have become acutely aware that concrete demonstrations, active participation with professionals and informal experiential training provide a most meaningful learning experience.

At the Lawndale Community Mental Health Center, we use psychiatric teams with Mental Health Aides (high school graduates) and Mental Health Workers in group therapy and in-home visiting for a teaching-learning experience. MSW's are team leaders over a particular program, while non-master's staff work on a peer level with them for teaching-learning purposes. No two MSW's nor two psychiatrists or psychologists, etc., work as a team.

The breadth of this approach extends to community agencies where

we request that workers from other agencies, particularly Public Aid, team with us in working with the mentally ill. This serves a twofold purpose of our staff: learning from as well as teaching the staff from other agencies. Board members serve as team members on programs; so do volunteers. There is no better way of informing a community of services than involving the people as volunteers on a service team. Volunteers should not be considered as a means of saving money for an agency but as a very real part of a treatment team in a therapeutic community. Good volunteers want to be guided and want to know how they fit into the overall scheme of things just like the rest of us.

Assessment of talents rather than titles is important. After my assignment to the Lawndale Community Mental Health Center in June of last year, the first thing I did was to interview each staff person as if he were being newly hired; then I observed and studied these people. Next we began to study the community and tried to assess needs. We declared one full day as "Lawndale Day" when each staff person, including me, took community assignments according to designated areas and did an all-day dialogue in the streets, taverns, pool halls, anywhere we saw people to assess needs. Following the assessment of needs, I concentrated on programs, then on whose talents (this was difficult) fit what job.

My secretary was designated as the Intake Worker with the Intake Team Leader, an MSW who was excellent in organizational schemes. Later, however, after the MSW was utilized to the fullest of his ability in that area, I switched to another staff person who had demonstrated a great deal of ability in seeing that schedules are kept, appointments made, etc. Another person who liked community contacts and had a lot to offer in the community was used as an ombudsman to follow up on patients who missed appointments. Another who was struggling with the angry, hostile patient was switched from direct treatment to socialization programs with Senior Citizens while we worked together on some of her feelings; she functions exceptionally well in her new capacity. The story goes on and on.

Once plans are formulated, it usually helps to have them written. A written plan outlining all the facts makes a program concrete. Each employee on my staff has a written job description with, of course, a last sentence that reads, "Performs other duties as required or assigned."

As you notice, thus far I have not said anything about blind persons--this was deliberate. What has been said pertains to any agency serving any group of people. Before I address myself specifically to blind persons, let me make you aware of some of my feelings.

I am opposed primarily to separatism. That includes this very conference. A separate conference for non-graduate persons sounds like a Trade Union. I am opposed to separate groups such as "Parents of the Blind." What can all parents of blind persons do except to support each other? Support each other in what? I am opposed to separate recreational

and group work facilities. I even question the concept of separate residential schools. Many employees in such settings have become over-protectors of their interests and of the people under their care. People are held captives, in prisons with or without walls. In many institutions serving blind persons there is a captor-captive relationship, not only for clients who are blind but staff who are blind. It makes little difference whether the person is in captivity because of his blindness or because of the staff-community attitudes.

Many of us are more concerned with what the community thinks of us as an agency rather than how we help the people in our care. Employees talk about what should be done but actually do little to bring about change. They are not able to make the investment of time and energy. I do not see blind persons as a separate people. There is no such thing as "blind social work" any more than there is Catholic, Protestant, or handicapped social work, unless we are referring to "blind social work" as working in the "blind" and "handicapped social work" as being "handicapped" in our work with the handicapped.

Although I have worked with blind persons, I am not an authority in this area, but I left with clearer views. I consider myself a healthy non-conformist, a recipient of challenges and enthusiastic about change and creativity, and I abhor "stick-in-the-muds."

In working with blind persons there is a need to differentiate the generic from the specific in dealing with the psycho-social problems. There should be some attempt to differentiate the many problems blind persons have in common with other handicapped or non-handicapped suffering human beings from those problems specifically attributable to blindness.

The adaptations of casework techniques in working with blind people differ only in degree, not in actual performance. The caseworker helps the person who is blind, not by placing undue emphasis on blindness but by taking into account emotional attitudes, medical and social realities.

In work with blind persons the caseworker needs to know the psychological implications of blindness. There needs to be some realization of the blind person's psyche in relationship to reality. What of the previous adjustment and mental equipment? Is the blindness total or partial? Adventitious or congenital? Is there a limitation of fields? Does he use what vision he has well?

Some concept of what blindness means to the individual who is blind is extremely important. The nature of the eye defect, intelligence, and emotional adjustments are all important factors in evaluating the vision as it affects the individual client . The social worker needs to know something about the family's adjustment to the person who is blind in reference to willingness to permit him to function as an individual and an independent person. The social worker must also be sensitive to the environmental attitudes within the group with which the person who is

blind associates. There must be some concern and knowledge about community resources and knowledge of how specifically these may be utilized in terms of an individual case. Another need is to examine the positive contributions the blind person can make within his own circle.

Blindness can be the reality which stimulates unconscious longings. Blindness can also accentuate dependency. It would often be safe to assume that the situation would be fundamentally unchanged if the person were not blind, although the emotional factors may not be so apparent. As an example, a rigid, cold worker who might later become blind would not be rigid and cold as a result of blindness, but would have been that way previously.

If a blind person is essentially dependent he may be unable to establish a positive identification with a blind caseworker. The fact that the worker has made her adjustment to life may increase the hostility of the client since the worker is a threat to him because she exemplifies the positive aspects in this situation which he cannot accept emotionally.

Just as a sighted child needs the opportunity or expression and growth, guidance and understanding of an adult who will be gentle yet firm, this child who is blind also needs to have this opportunity for growth and development. There is the same need to nurture, structure and include a blind child as there is for a sighted one. Acceptance is important; acceptance is a vitamin. We all hunger to be accepted as we are. We want someone with whom we can relax.

The child who is blind passes through the same stages of development such as oral, anal, oedipal, etc. as a sighted child. A thirteen-year-old blind adolescent does not masturbate because he is blind, but probably for the same reasons as a sighted thirteen-year-old. Our understanding of the problem would not be based solely on his blindness. A blind young woman may become pregnant out of wedlock the same as a sighted one. The needs of blind people are basically the same as those of sighted persons. Too constant help reminds the blind person of his handicap.

In working with blind persons, there are tendencies toward two extremities that need to be avoided:

1. Concentration on the development of particular services without adequate evaluation of the individual and social factors.

2. Emphasis exclusively on understanding the emotions of the client in order to help the client mobilize his energies to move forward, with insufficient regard for the practical aspects of handling the disability itself.

This may sound elementary, but how many of us have given thought to the many different uses of the eyes? I have listed a few:

1. The eyes focus and select.
2. They grasp details of form, size, and color.
3. They grasp the relation of objects to each other.
4. They close voluntarily or involuntarily.

The person who sees has greater control over his environment; he can select the person he wishes to come in contact with or avoid. A totally blind person feels himself in a vacuum; everything cannot be heard or touched, and therefore he can obtain only a partial concept. A blind person cannot hear a table, chair or chandelier --touch cannot go beyond the length of an arm or cane--cannot feel moving objects such as a truck coming down the road nor large objects such as a building. We should recognize that the fear of the possibility of colliding with something while walking increases nervous tension and fatigue.

In the interview situation, the caseworker should be careful to avoid occurrences of prolonged silences. While permitting silence to prevail occasionally may be a good approach with sighted individuals, it is courting a break in the relationship between the sighted worker and the blind client. While the sighted worker and client can keep contact and communicate by facial expression and gestures, the blind client has no way of keeping in touch with the sighted worker during these silences. Therefore, he may feel at a disadvantage. For this reason greater skill and security on the part of the worker may be necessary in making comments and posing questions in order to maintain the verbal contact with the client and yet leave the client free to express himself along the line of his own interests.

Social isolation, I am told by several blind persons, does not have the same significance as for sighted people. Social isolation for blind persons in many instances, it is said, may prevent mental breakdown, as it is easier for the blind person to cope with the isolation than it is for him to compete in a social situation or setting where he tends to feel rejected or unhappy. Many may use fantasy, such as daydreaming, as a means of coping with isolation; while relatively passive pursuits, such as reading, listening, writing, and the use of mental games, may be very important. Also, it is assumed that the social isolation of blind persons is acceptable by society and there are no undue pressures by peers, community, etc. to get out into the world.

These are tempting assumptions for both blind and sighted persons. The insidious nature of such rationalizations seems to be rooted in a desire or belief that blind persons have special inner help, even uncanny resources which compensate for their handicaps. Thus, our adjustment to dealings regarding the handicap can be fairly easily achieved. But the isolation of the blind person is perpetuated, and there is no need to face or examine existing problems, and no stimulation for change of existing attitudes or services.

Action Implications for Agency Staff and Blind Persons:

1. Blind people must take the lead by refusing to play the bureaucratic and cultural games which are offered as the way to rehabilitation, and to demand truly individualized services in which they are active participants, not passive receptors. A program is needed to change community and employee attitudes through education, social action, and active inter-agency collaboration.

2. A communication network should be developed to function as the clients' advocates in their efforts to secure services from agencies within the area where the blind person lives.

3. Blind people must learn to evaluate existing services, formulate and assert their needs.

4. There is a need for the development of self-awareness of one's own attitudes and what can be done for self in the area of change.

5. There is a need for our institutions set up to serve blind persons to stop planning the lives of blind people and to respect the right of the client to think and plan, with some guidance, for himself.

6. Attention must be given to the problem of avoidance. Avoiding issues with clients can create additional problems. Blind people are not as fragile as we think, and many of us avoid them because of the fear of responsibility for what might happen to the blind person.

7. There is need for expanding vocations open to blind persons. The more the blind person is truly looked on as a worthwhile participating member of society instead of a helpless person in need of pity, the more he will be integrated into society. Vocational experiences would not have to be limited to those monotonous choices that are now available.

8. Registering blind children at the time of birth so that the family can be offered assistance if desired during the early and most formative years might make a profound difference in many areas on the lives of blind children.

9. Administrators and professionals should train our most needed non-professionals and regard them as people with something to offer.

BIBLIOGRAPHY

Berne, Eric. Games People Play. Grove Press, Inc., 80 University Place, New York, N.Y.

Rosenberg, Janet. Two Jars of Paste for Breakfast, A Training Manual for Para-professionals in the Human Services. Cleveland College, Case Western Reserve University.

Reissman, Frank. Strategies Against Poverty. Random House, New York, N.Y., 1969.

Giblin, Les. How to Have Confidence and Power in Dealing with People. Wilshire Book Company, 8721 South Sunset Boulevard, Hollywood, California 90069. 1956.

Shulman, Lawrence. Social Systems Theory in Field Instruction, A Case Example. The General Systems Approach, Contributions Toward and Holistic Conception of Social Work, edited by Gordon Hearn, Council on Social Work Education, 345 East 46th Street, New York, N.Y.

III - SMALL GROUP DISCUSSIONS

Discussion Leaders	Recorders
Miss Karen Schiller	Mrs. Greta Gaston
Miss Betty J. Marino	Mrs. Denise Schidler
Mrs. C. Wendy Henny	Mrs. Mary M. Houston
Mrs. Carol Bradford	Mrs. Carol Bradford
Mrs. Hazel Sizemore	Mr. H. David Weller
Mrs. Helen Johnson	Mrs. Constance L. McMullin

During the second day of the institute, there were two opportunities for the entire group to break up into three small groups for the purpose of facilitating exchange of ideas and to permit everyone to have opportunity for discussion. Each of the six groups had discussion leaders and recorders, and reports of these group discussions were later made to the whole group.

The first series of small group discussions took place immediately following the presentation of the paper Challenging Traditions, and there was much heated reaction to the paper which became the focus of this series of group discussions.

Some felt strongly that they had asked for help in answering the questionnaires, while the speaker had ridiculed them for their questions. Another main issue of each of the groups was the question of the values of separate as opposed to integrated services for blind persons since the speaker had taken a strong position against separatism.

Another main issue which emerged from the groups was the question of professionalism. It was evident that many speaking on this issue considered themselves as professionals who felt that they had been downgraded by this speaker. Many felt there was too much emphasis on status. However, it was also felt that it is an individual's personality rather than his education which determines his attitude. Some felt professional education could be harmful by making the person feel superior to his client.

In the second series of small group discussions, division was made among those concerned with residential treatment, those who go out to their clients, and those whose clients come into the agency. Again, the major concern of each group seemed to be with the values of generalized as opposed to specialized services, with general movement toward recognition of the needs for both, the assets and appropriate use of each, with less defensive involvement with an indivdual's particular setting.

Related to this concern there was considerable discussion regarding the impact of blindness on the individual, his emotional functioning

and the extent to which this was caused by blindness. These points were related to needs and techniques of individualizing the client and understanding him as a person rather than as a blind person.

The reports of the small groups provided much material for general discussion and reinforced the earlier case discussion. It was evident, too, that one great benefit derived from the small group discussions was the opportunity for more exchange of experiences and common problems.

IV - GENERAL SESSIONS

A. Case Discussion

A case record which had been given to all participants to read previously provided material for discussion which covered a considerable range of concerns. While the record cannot be described in detail here, the case which came under discussion was a very typical situation of a lonely, depressed, very anxious woman whom the caseworker was attempting to encourage to utilize agency services which on the surface seemed to be rational solutions to the problems with which the client was faced. Questions centered around the goals of the worker and how she was attempting to help the client. Most participants felt there was a need to create independence and get her interested in outside activities as boredom, stagnation and isolation seemed to be outstanding features in the case.

The participants were directed to consider what their goal would be for the client. One person suggested she should be put in a rehabilitation center; another thought she needed psychiatric help for her complaints of nervousness; other ideas were to get to know her as a person, find out what she was like before her blindness came on. The group struggled to understand the problem of the client's lack of movement despite the worker's efforts to be helpful.

Many ideas came out of the group and led into a general discussion of counseling and how to get people motivated to accept service and yet not impose one's own solutions. Getting down to basic elements, there was discussion of "How does one do counseling?", "How does one establish a relationship with a stranger, become a friend, a friend with some emotional influence?" In any attempt there are pitfalls which represent the extremes which are natural problems when one is trying to learn the true nature of a professional as distinguished from a natural social relationship. One may approach the client with an attitude of neutrality, an avoidance of sympathy; or one may misunderstand empathy and convey to the client that he need not worry any longer, everything will be done for him. In either case, there is a lack of real communication and material understanding which could lead to an emotionally significant interchange.

The case being discussed seemed to be familiar enough to everyone's own experience--the frustration of making initial progress and then meeting with resistance. Though frustrating, resistance at some stage is common and to be expected. However, one's own feelings at this point may interfere with attempts to understand the underlying emotional significance of the client's behavior.

One must consider whether one has picked a relevant goal. There was considerable discussion here. There may seem to be some contradiction between the client's freedom to choose his own goal and the worker's

appraisal of whether the goal is realistic. It was pointed out that if a client is working on a set of unrealistic goals, the worker's job is to tell him and let him decide. If the client is evading reality, that must be pointed out. It is still the client's decision whether to attempt to work on the problem more effectively or go on avoiding or evading. We can point out the conflicts and the consequences as we see them, but the client must make his own decision.

It was emphasized that many problems arise because there has not been a clear understanding in the beginning. In the beginning of the casework relationship there is the principle of a contract established between the worker and the client as to what they are going to do together or what they expect. If there is no contract clearly understood, either party much later may be badly disappointed and disillusioned.

B. General Discussion

We must give some thought as to the method we are using and help in a rational way to sort out issues, clarify problems and conflicts with reality. We can discuss the feasibility of various courses of action and free the client to assume responsibility of making a choice. To do this, it is important that he feel free to make a choice, and that we point out the choices, the consequences and the responsibilities involved. We can help the client to assess where he is, here and now, and what he wants to do about it. We cannot decide for the client but must leave the decision to the client himself. We can only point out the consequences of various courses of action as we understand them and his own needs and behavior in the situation. It is possible for a person to learn acceptance of himself by having the experience of being accepted by another.

Let us consider treatment. First of all, treatment is a corrective emotional experience through a relationship. It is helping the client to clarify his problems and his feelings about them. The techniques aim at supporting and strengthening his ego; offering opportunities to drain off emotional tensions. Helping to diminish, dilute and resolve emotional conflicts all serve to strengthen the ego and to support the client in his efforts at solving his problems.

We have been talking about the basic methods used in casework in general. In agencies serving blind persons there are certain special features; for example, the teaching of Braille, typing, travel, personal and home care, vocational choice, retraining preparation. While these may be specialized, the method is not. The underlying method is generic to the field of social work. Social casework with blind persons differs only insofar as any specialized service does--nature of need, structure and function of agencies, and skill of the worker differs.

If we look at the blindness and what it means rather than the person and concentrate on this, we are actually defining blindness as a role; and in specialized agencies it is often the only role the blind person is permitted. In other words, he is subordinate and, therefore, enforced dependence may result. Social deprivation can result from the stereotype, being forced into a role of "the blind person" and not permitted any other role.

The diagnostic problem centers upon differentiating as to whether the roots of responses do lie within the area of "normal" responses to frustration, or whether they are symptoms of emotional disabilities unrelated to blindness, in which case the worker will need to arrive at a diagnosis of the nature of the emotional disability (or neurosis) and design a treatment approach accordingly. Just as the sighted client may be suffering from a neurosis which is rooted in his personality structure, so may the blind client. While it may be aggravated by his blindness, or its form of expression may be conditioned by blindness,

it is not caused by blindness per se and consequently is subject to the same diagnosis and treatment used with sighted clients. Treatment is the sum of all activities and services directed toward helping an individual with his problem.

A person is motivated to change because of the hope of satisfaction. He can be motivated by an educational and helping process which clarifies a course of action and offers the tools or resources with which to give satisfaction.

The key to treatment, however, is the relationship, the personal encounter with emotional interchange with someone whose interest is invested in freeing the client to pursue his objectives. The objectives and treatments might be:

--A change in the problem of persons and situations by supplying a social resource;

--Changing attitudes or behavior;

--Both.

The question is whether to treat and help a person in a specialized agency serving blind persons or to refer to another resource. The question is what to do in the light of the presenting request, the diagnosis, and what the client seems able and willing to undertake. One must ask the question, if the problem stressed is blindness, is the client's problem one of coping, ego strength, depression, self-image, behavior, or is the problem blindness itself? Is the problem even blindness--or is this the precipitating or the unbearable situation?

--Alienation may result. Under severe stress and the combination of emotional reactions which have been mentioned, alienation is a common feeling. There is also a feeling, "I hate you all, and especially those of you who can see and who can help me." This results in part from the hatred of dependency and the resentment of the need for dependence and help.

There are some personality characteristics which commonly emerge either as a result of a handicap or because they were already there. These are some of the ways people react to trauma:

--In a passive way--those who drop out.

--The aggressive ones who act out.

--There is a combination, the passive-aggressive ones, and these individuals turn to resistance.

--A schizoid pattern--those who become withdrawn.

There are persons with paranoid tendencies who react by blaming others, by hitting out, by becoming suspicious of others' actions.

Some consideration needs to be given to the defenses, the means to which people resort to protect themselves when they feel vulnerable. These defenses range from projection, to denial, to rationalization, to partializing, to sublimation, and reaction.

In the concept of stress, of coping, adaptation, and change, the following questions are of significance:

--When did the client become blind?

--How did it come about?

--What is the ideology of blindness?

--Is there competence within the family, other contributary factors such as the competencies or liabilities within the client, in the family, their social and economic status, poverty, minority status, etc.?

--Are blind people a put-down minority, insulted and given no respect and seen in a stereotyped manner?

Treatment is ego building. The stages of man, the experience as the child grows, and the ways in which he passes from one stage to another determine his ego strengths and his adaptive capacity to stress.

Let us consider the concepts of point of entry and leverage in treatment. The worker assists the client to choose and use another community agency through a relationship which occurs within the course of the interviews, the exchange of information, the explanation.

Diagnosis is the appraisal of the client's own strengths, resources and ability to use help to move, and his power in decision making. This type of service is of major importance. It involves several important steps:

--Individualizing the client.

--Diagnosing and understanding the problems that the client has, both those which are stated and those which are conveyed in non-verbal behavior.

--Motivating the client for self-help, self-awareness and responsibility.

Some consideration must be given to the emotional components in the problems about which we have been speaking. We referred to blindness as a stress, and an extraordinary stress. Some common reactions to this stress are:

--Anxiety.

--Fear of an endangering environment.

--Anger which may come as a result of frustration.

--The client under such stress naturally asks the question, "Why me?"

--The client has a concern about how he will be treated.

--He may have no outlet for the anger which he feels, and there is self-doubt.

--Shame may be a common accompaniment that results from an altered self-image which leads to questioning a person's abilities and integrity as an individual.

--Guilt. If one is afflicted with a handicap, there is a natural feeling to ask the question, "Have I been bad? Why am I being punished?" because the handicap may very well seem like punishment.

--Role must be considered. A person with a handicap must ask himself, as everybody does, "Who am I? Where am I? What can I be?" There is a need for the search which inevitably occurs for the real self, and it is important for the individual to come to a feeling that he knows his real self and sees himself as a person and not as a handicapped person.

As social workers, we must be alert to and encourage the client to be able to wish and do. We must help him to be free of fear of failure and punishment. The social worker must support the client in finding a reasonable goal or goals so as to look forward to tomorrow and getting out of bed.

The client needs to know that someone significant cares, that "What happens to me and whether I live or die matters," and to have someone care helps one to feel useful and needed. We must consider the casework session as a corrective, enhancing and reinforcing emotional experience.

What is casework method? It consists of a supportive relationship, the use of cognitive approach and conditioning.

What is the casework relationship? It is seeing the situation as the client sees and feels it and conveying some confidence and hope that the situation can improve. It is approaching the client and the problem with a problem-solving attitude and demonstrable experience. This means a growth-inducing experience. It means an enablement which conveys confidence, support and willingness to try on the part of the client with the feeling that something is to be gained.

Most social work problems are interpersonal. The goal of the social worker is to enable another to realize his own capacities for change and growth. To do this one must know how a person feels about his situation; one must be able to perceive his problems as he sees them in his frame of reference and within his impinging environment.

C. Summation
Dr. Alan Klein

Let us think back to what we have been doing in the past few hours and days. First we opened with an attempt at understanding people and helping them in coping with their social relations. This is what social work is. We have tried to see that persons who are blind have the same ego strengths, defenses and personalities that anyone else has, though it does depend on what effect the blindness has added.

Blindness accentuates the interpersonal relationship difficulties. It impedes interpersonal reactions, interaction and communication. It is a great stress. Much of a person's behavior has been learned, so the handicapped person brings established patterns and introduces much of his previously learned behavior into the helping relationship. The social worker must direct himself to understanding what the basic behavior means. He must be willing to listen, to determine what the client wants and not impose his own wishes.

People under stress have certain basic reactions which are basically human--they have a tendency toward rationalization, partialization, sublimation, reaction and denial. Everyone uses these defenses; these are not peculiar to blind persons. Because of some realistic differences, however, there is a question about the values of services provided through generalized agencies or specialized; i.e., integration as against separatism. This depends on the person, on groups, and agencies, specialized or general. There are values of purpose in each, but they must be used knowledgeably--in relation to a particular person's needs, and not determined by individual prejudice or tradition.

We have considered the matter of professionalism, the question of status, "credentialism," competence in relation to levels of service. Those in this room are regarded as professionals and feel that way. We must define levels of service and know when to refer to others who are more expert than us. We may regard professionalism as preciousness, status seeking, security, or we may regard it as a commitment to sound methodology, continuing education, and ethical responsibility. If we accept the latter, then the basic steps in acquiring a methodology must follow. The social worker must individualize the client, determine the problems and utilize them objectively and knowledgeably. The major responsibility of the social worker is working for the client--not for a system, an institution or tradition. Treatment starts when the client realizes this.

We have considered the need for more social workers and in-service training programs. Some of you have indicated having uncomfortable feelings that many people are not being reached with needed services, that what is provided may often be necessarily limited to almost token gestures. Some have spoken of a fear of spreading information about existing services as these might easily be overwhelmed by a greatly

increased demand stimulated by such information. Many of you have indicated that you have direct knowledge of how human services become too great to manage with existing resources.

We have considered the need for change. A predominating theme of our discussions has been the question of generalized versus specialized services, which seems to reflect a general concern as to whether the existing structures of agencies are truly serving the best interests of clients; and while we have recognized the value of both generalized and specialized agencies, the important point is to be able to test our assumptions, beliefs, our accepted ways of doing things in order to improve our services and utilize our resources most effectively.

Again, in line with concern for truly meeting the needs of our clients is the wish not to institutionalize, not to impose our own values or needs. Here there has been recognition of the importance of lay organizations. We should consider how to assist clients in getting organized and demanding that their needs be met. Perhaps they should move more toward securing necessary legislation for needed programs.

We have considered our relation to other people and the difficulties and weaknesses in interpreting our own role. We are weak in interpreting to our communities what specifically we do that is different from other helping professions. More consideration must be given to community relations and our activities in this area. As a means of conserving staff time and expanding services to more people, we have considered the need for greater utilization of groups. More experimentation is needed here, with more emphasis on this treatment modality by professional schools and in-service training programs.

There has been a wish expressed that AFB could have more such institutes as this for all types of professionals. Specifically, it was mentioned that ophthalmologists need more understanding of the social and dynamic impact of blindness, as well as more knowledge of the benefits, services and resources available to their patients.

The implications are clear: There are many problems and stresses which all of us must cope with as social workers. We can accuse; we can say the problem is credentialism, professionalism--either too much or too little--institutionalization, or tradition. We are involved with broad social problems which are all too often beyond the scope of any individual no matter how skilled and beyond the scope of any one profession. Nevertheless, most of you have demonstrated your concerns and your wish to improve the services you are giving, despite the obstacles with which you may be faced. These are obtainable goals, and we need to hold with them.

V - CONCLUSIONS

At the end of the institute the participants were given questionnaires (a copy of which is in the appendix) to complete anonymously regarding their reactions to the institute.

As for the participants' evaluation of the institute, there was a consensus--on at least one point. Their responses left little doubt that the opportunity to meet together with a large number of persons engaged in similar work, the opportunity to exchange experiences and problems, was greatly appreciated and valued. Almost all participants expressed a hope that there could be more such institutes.

Most participants expressed in very positive terms that the institute had been a very meaningful learning experience, but consensus seemed to end here. About an equal number favored more time for the speakers, while others felt there should have been more small group discussions. Many felt that one speaker had been provocative to the point of "turning them off," while others felt that the provocative notes had roused them to participate more actively. Many indicated that some of their most fruitful discussions had taken place outside the formal sessions in their informal meetings as they got acquainted with each other and could share experiences and concerns in a more immediate and intimate manner.

As to content, most participants felt it was relevant and immediately useful in helping them with some of the problems and questions which they were experiencing. However, one person who indicated that she got no answers to her questions was perfectly satisfied that no one else at the institute was able to answer her questions, and she seemed to experience much relief! Naturally, some wished for content more specifically focused on their immediate needs.

These proceedings of the institute cannot begin to reflect the range and depth of questions and concerns which emerged during the course of three days of meetings. For the most part many of the issues could not be dealt with fully, as each would have required a separate institute and involved very broad and complex social problems. Rather, an attempt was made to deal with issues within the generic framework, with the hope that the participants would be able to find in general principles some guidance in the development of knowledge and skill which they might apply to their own immediate practice situations.

There were many suggestions made by participants for content for future institutes. Frequently these were problem and age focused; as for example the needs of very young blind children, services for multiply handicapped children, and services for aging visually handicapped persons. Others focused on treatment modalities and with interest expressed in learning more about family and group therapy.

The need for more such institutes seems to be clearly established, and AFB, in its program of continuing education, hopes to have more such institutes. For those of us engaged in the operation of this institute, the enthusiasm and serious involvement of the participants make us look forward to future institutes where there can be similar freedom of exchange of knowledge, challenge and learning in the interest of improving services to clients.

NATIONAL INSTITUTE FOR WORKERS IN SOCIAL SERVICES
IN AGENCIES SERVING BLIND PERSONS

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AMERICAN FOUNDATION FOR THE BLIND
PROGRAM DEVELOPMENT DIVISION

PROGRAM

National Institute for Workers in Social Services
in Agencies Serving Blind Persons

The Midland Hotel
Chicago, Illinois
April 16-18, 1970

Thursday, April 16, 1970

2:00 p.m. - 3:00 p.m. Registration

Welcome

Speaker: Miss Norma K. Fike, Director
Personnel and Training Service
Program Development Division
American Foundation for the Blind
New York, New York

"What is AFB?"

Speaker: Miss Marion V. Wurster, Director
Program Development Division
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3:00 p.m. - 3:30 p.m. Coffee Break

3:30 p.m. - 4:30 p.m. "Setting the Stage: Where Are We and Where Are We Going?"

A preview and overview of theories of serving persons in specialized and generalized agencies. Development of social services.

Speaker: Dr. Alan Klein
Professor, School of Social Welfare
State University of New York at Albany

5:30 p.m. Social Hour

Friday, April 17, 1970

9:00 a.m. - 10:00 a.m.	"Challenging Traditions" Speaker: Mrs. Lucy Chappell Executive Director Lawndale Mental Health Clinic Chicago, Illinois
10:00 a.m. - 10:15 a.m.	Coffee Break
10:15 a.m. - 11:45 a.m.	Small Discussion Groups
12:00 noon - 2:00 p.m.	Lunch
2:00 p.m. - 3:15 p.m.	Different small discussion groups on specific needs of various ages and degrees of disability
3:15 p.m. - 3:30 p.m.	Coffee Break
3:30 p.m. - 5:00 p.m.	General Session Reports from the small discussion groups

Saturday, April 18, 1970

9:00 a.m. - 10:30 a.m.	Small Discussion Groups around specific interests
10:15 a.m. - 10:30 a.m.	Coffee Break
10:30 a.m. - 12:00 noon	General Session Reports of groups and reporters Summarization - Dr. Klein

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in Agencies Serving Blind Persons

Chicago, Illinois
April 16-18, 1970

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AMERICAN FOUNDATION FOR THE BLIND, INC.

M E M O R A N D U M

March 13, 1970

TO: Participants of the National Institute for Social Workers

FROM: Norma K. Fike, Director, Personnel and Training Service

SUBJECT: Program for National Institute for Social Workers

We appreciate very much your interest in participating in the National Institute for Social Workers.

To make this as rewarding and as useful as possible for everybody participating, we ask your cooperation in answering the following information:-

1. List the three or four most important responsibilities which you feel you have in your capacity as social worker.

2. Please list the problems or areas which you feel would be most helpful to be taken up in the institute.

3. Could you, or would you be willing to, submit case material to illustrate the above problems or areas of interest?

It is very important that you return this information to us as soon as possible.

NKF:cf

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THE LEGACY OF HELEN KELLER

Helen Keller inspired millions throughout the world by her triumph over deafness and blindness. She used her personal miracle of communication to open the world for other blind and deaf-blind people. She appeared before legislatures, gave lectures, wrote articles, and above all, made herself an example of what a severely handicapped person can accomplish. When the American Foundation for the Blind was established in 1921, she found in it a national organization that shared her purpose. From 1924 until her death in 1968, Miss Keller was a member of the Foundation staff, serving as counselor on national and international relations. It was also in 1924 that she began her campaign to build the Helen Keller Endowment Fund for the Foundation. Through this fund and the kindness of present benefactors her work is continued.

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American Foundation for the Blind

National Institute for Workers in Social Services
in Agencies Serving Blind Persons

April 16-18, 1970

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(Please complete and return - you need not sign your name.)

1. Has this institute been a learning experience for you? If so, to what extent?

2. Has it supplied answers to some of your own questions? If so, to what extent?

3. Was there sufficient opportunity for discussion?

4. Would you recommend future such institutes? If so, what subject matter do you wish considered?

5. We would appreciate any additional comments on the institute. Please include your observations re: its focus, content, structure and physical aspects. (Use reverse side of page, if necessary.)